# PHILADELPHIA NEUROLOGICAL SOCIETY.

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The President, Dr. Wm. G. Spiller, in the chair.

## PERIPHERAL FACIAL PALSY WITH CROSSED HEMIPARESIS.

Dr. F. Savary Pearce presented a colored man, teamster, aged 58, with crossed paralysis, in whom the hemiparesis seemed in some way connected clinically, at least, with the complete peripheral paralysis of the seventh nerve. The man came to the clinic of Dr. J. Madison Taylor at the Howard Hospital on the seventeenth of June, 1899, presenting complete left facial palsy. There was no trouble with the musculature of the limbs at that time. He stated that three days previously he noticed that he could not close his left eye, the complete facial paralysis rapidly supervening. It is likely the real paresis began four weeks earlier when he sat in a draught for some time. This exposure was followed by pain in the left parietal and mastoid regions, with tenderness on pressure over the same areas, existing in some measure up to the present time. He was treated by blistering and potassium iodide in five grain doses three times a day, and was referred to the ear clinic where suppuration of the left middle ear was diagnosed and treated by Dr. Vansant. There was no disturbance of sensation over the paretic area, nor was there any disturbance of the sense of taste, but the tip of the tongue was pushed toward the right when protruded. The man was treated carefully with descending galvanism during the summer which seemed to restore in part the paretic facial muscles. There has never been more than the slightest alteration of the formula as evidence of degeneration of the left facial nerve. In October, 1899, Dr. Posey examined the eyes and found the discs normal and no changes in the fundi. There is at the present time some tenderness over the left mastoid region, but the ear has ceased discharging.

The man was admited to the ward in October and remained under galvanic treatment with continued use of iodide of potassium and 1-20 grain doses of strychnine for seven weeks. There has been practically no permanent improvement in the face.

On December first, in the morning, while walking upon the street he became dizzy, nauseated, and finally vomited much bile. He then became dazed, and had to be carried home. He was found to be feeble in the right leg and arm and was unable to walk for some time. He came to the clinic again on February 24, 1900, at which time both knee-jerks were found to be increased, especially the one on the right side; the right arm and leg were feeble, and the tongue was slightly protruded toward the right side.

Dr. Pearce thought that the cause of the left facial paralysis was septic otitis media with extension and perhaps permanent impairment of the seventh nerve. The sudden onset of hemiparesis of the right side of the body, three months later than the beginning of the left Bell's palsy, suggested to him that an abscess had developed in the left motor region of the cerebum secondary to the ear disease; or that a primary hemorrhage involving the left motor area of the brain had occurred. Although there were no symptoms of abscess of the brain, Dr. Pearce thought that a pus collection extending by contiguity from the septic left ear might be the remote cause of both paralyses.

Dr. Charles W. Burr thought that the most natural explanation was that the man had Bell's palsy, and, later, an apoplectic attack. Hemiplegia from abscess is not very common, because an abscess is not usually in the motor region.

Dr. F. X. Dercum remarked that Bell's palsy as an independent affection in hemiplegia is not very uncommon, and abscess almost never gives rise to hemiparesis.

Dr. William G. Spiller agreed with Dr. Burr and Dr. Dercum that the crossed paralysis was probably the result of two different lesions. Abscess from ear disease is more commonly in the temporal lobe, and if hemiparesis had occurred by the extension of such an abscess to the internal capsule, we might expect to find symptoms of sensory aphasia in this case, the lesion causing hemiplegia being on the left side of the brain. He referred to a case seen by Dr. C. K. Mills and himself, in which there was paralysis on the same side as the facial palsy, developing at a different time. A hemorrhage into the optic thalamus had occurred, and the paralysis of the facial nerve was an independent condition. In this case, the center of the facial nerve afforded an interesting study, as it was possible to distinguish by the altered cells the side of the pons belonging to the affected facial nerve.

## A CASE OF ACROMEGALY.

Dr. W. G. Shallcross, by invitation, presented a male of eighteen years with acromegaly. The disease had only been recognized for about two and a half years, though the history showed that it may have had an earlier origin. The symptoms began to develop after an acute illness.

He was born in normal labor, and was the first child of his parents. His father was below the average in intelligence, and was deaf. The patient has one living brother, normal in every respect. In August, 1892, he was described as being of the usual weight and size for his age. His head was of normal shape, and his features were long. In walking he bent forward, and in speaking stammered a little. He commenced to walk when sixteen months old.

In 1892 he entered the Pennsylvania Training School, where he made fair progress, and soon learned to read and write, and was regularly promoted from time to time. His mental development continued until April, 1896, one year previous to the onset of the symptoms of acromegaly. By this time he had reached the highest grade in the Pennsylvania Training School, which is attained by only a small minority of those under instruction. From now on until the present time his mental faculties have progressively lessened.

In 1897 he began to grow rapidly, and the peculiarity of growth which is so pronounced now was then noticed. From the average build of a boy of fifteen years of age up to the present time, in three years, he has grown to his present extraordinary development. The hands are symmetrically enlarged and out of proportion to his body. The bones and soft parts have shared equally in this hypertrophy. There is apparently no thickening of the bones at the articulations, and the hands present the so-called spade-like appearance of the English, or the battledore head of the French. Fleshy pods on the palms, so often described in this disease, are well shown here. The fingers are long and sausage-shaped. The feet correspond in the main to the description given of the hands. They are, respectively, right, twelve and one-quarter inches; left, twelve and one-half inches long, and he wears what is known as a number 15 shoe. The face is strikingly characteristic. Its oval contour, the long and broad nose with dilated nostrils, the thick lips, massive malar bones and lower jaw give to it a decided prognathism. The lower jaw has grown forward about one-quarter of an inch in the past year, so that the normal articulation is lost.

In speaking the voice is noticeably altered. It has the peculiar deep resonance that is so frequently heard in patients suffering from acromegaly. The tongue is long, broad, and deeply fissured, and seems unwieldy; in appearance it resembles closely this organ as seen in the cretin or the Mongolian type of imbecility. The soft palate and uvula are correspondingly enlarged. The larynx is rather large, and the neck thick. The right thyroid lobe seems to be distinctly enlarged and quite firm.

The spine shows a dorsal kyphosis which dates back several years, at least, before the disease developed. The thoracic cage bulges forward, and the antero-posterior diameter is increased as compared with the lateral. The abdomen is pendulous and the breasts markedly enlarged. The sternum and clavicles are hypertrophied. This increase in the size of the latter is particularly noticeable on their inner thirds. The ribs are broad and flat, and at their junction with the sternum are noticeably beaded. The bony framework seems everywhere enlarged. As the patient stands in his stocking feet he is six feet three and one-half inches in height, and when stripped weighs 200 pounds. In a little more than a year he has grown one and one-quarter inches in height. The weight, however, has remained the same.

Hearing shows no change as tested by watch; right ear, six inches; left ear, sixteen inches. Smell is normal; taste is also normal.

His gait is peculiar, and is largely due to the tilting of the pelvis, caused by deformity of the right knee and the effort at maintaining equilibrium, made difficult on account of the kyphosis. .

His station and sway are normal. Cutaneous reflexes and knee-jerks are diminished. His strength has progressively failed. Grip, as tested by dynamometer: right hand, 40; left, 35. Hyperhidrosis, so common in these cases, is more marked on right side. The skin is appreciably thickened, and over his shoulders, sides of chest, and lateral surfaces of abdomen it is thrown in rugæ.

Dr. Francis X. Dercum said that this was undoubtedly a case of acromegaly in which there was associated gigantism. It suggests the thought that when acromegaly begins in early life, before the epiphyses and shafts of the bones have become united, there may be increase in the length as well as the breadth of the bones. The case he considered a very interesting one, although not as typical as some, probably because it was in course of development.

Dr. Charles W. Burr reported a case of treadler's palsy.

Dr. John K. Mitchell referred to a similar case he had seen in which there was cramp as well as palsy in the posterior muscles of the lower leg. It was a comparatively acute form, the man having been working only a few months. He was completely cured by rest and galvanism.

Dr. A. A. Eshner said that a similar disorder had been observed in motormen from excessive ringing of the gong with the foot.

## A CASE OF AMYOTROPHIC LATERAL SCLEROSIS.

Dr. Charles S. Potts presented a case of this disease in which the especial points of interest were the possible influence of lead in the etiology, the unilateral distribution, and the rapid development of the symptoms.

The patient, a man 42 years of age, had worked in lead works for eighteen months. Nine months ago he had an attack consisting of pains in the stomach, and constipation, which his physician called lead colic. About six months ago he noticed weakness of the left leg and his toes caught in any object projecting above the level of the floor. Very shortly after this the left arm became weak, and at about the same time indistinctness of speech and difficulty in swallowing were noticed. He had not observed any weakness of the right side of the body. but examination showed it to exist.

Dr. James Hendrie Lloyd said that in its rather recent onset, and in many of its clinical aspects, this case resembled one which he had recently had in the Philadelphia Hospital. His case began acutely last fall with symptoms of irritation of the spinal meninges. When admitted, one month ago, the patient was found to have amyotrophic lateral sclerosis, with a spastic gait and ataxia, marked fibrillation, and slight muscular atrophy, most marked in the essential muscles of the hand.

The lesion of the cord seemed so acute that it suggested the propriety of lumbar puncture for the purpose of making a bacteriological study. Two punctures were made with practically negative results.

In Dr. Potts' case lead may have had something to do with the causation. The symptoms of lead poisoning are not confined to the classical wrist-drop. Well-marked cases of muscular atrophy have been reported in persons who have long been exposed to the action of lead. He had himself reported one such case in the article on occupation neuroses in the "Twentieth Century Practice."

Dr. Francis X. Dercum alluded to the existence of bulbar symptoms in this case, and referred to a case of amyotrophic lateral sclerosis reported by Dr. Spiller and himself, in which bulbar symptoms were present. He commented upon the frequency of bulbar symptoms in amyotrophic lateral sclerosis.

Dr. William G. Spiller called attention to the interesting fact that in Dr. Potts' case the disease began as an unilateral affection. Usually when a case of amyotrophic lateral sclerosis comes under observation the paralysis is symmetrical on the two sides of the body, but cases with unilateral symptoms are on record. In Dr. Potts' patient the disease had a rapid development. Dr. Spiller had recently exhibited a case of amyotrophic lateral sclerosis in which the symptoms had not progressed during two years.

Dr. Charles W. Burr presented a woman with general anesthesia, who was blind and deaf, and whose movements were very inco-ordinate.

Dr. Charles K. Mills asked where Dr. Burr thought the meningitis and meningoencephalitis were located. He referred to a case in which the autopsy showed meningitis and meningoencephalitis of both posteroparietal regions. This man had anesthesia of both halves of the body, but not general anesthesia. He had other symptoms, such as athetoid movements and some hyperesthesia.

Dr. F. X. Dercum said that an important point was that there was no pain and no motor involvement. It was strange that only a general surface anesthesia with involvement of the optic and auditory nerves should be produced by a meningitis.

Dr. William G. Spiller suggested that the lesion might be in the optic thalami and the tracts from the corpora quadrigemina passing close to the optic thalami. The headache, vomiting, optic atrophy, and other symptoms might be explained by involvement of the optic thalami. Loss of hearing might be produced by involvement of the tracts from the posterior colliculi of the corpora quadrigemina to the temporal lobes. Such a diagnosis could only be held as a possible one.

Dr. Charles K. Mills was inclined to doubt the diagnosis of meningitis in this case. He thought that the lesion was a more localized one involving the sensory tracts or the thalami.

Dr. Charles W. Burr did not wish to be understood as asserting positively that this woman had meningitis, although he thought this diagnosis explained the symptoms. The exact nature of the lesion, he thought, could not be determined unless an autopsy were made.

## A CASE OF RHIZOMELIC SPONDYLOSIS.

Dr. F. X. Dercum briefly placed on record the following case which apparently belongs to the group of cases described by Marie and Astie, and others, in which progressive rigidity of the spine is the most prominent symptom. Simple spinal rigidity may be the result of various morbid processes. Thus in the affection described by von Bechterew as lepto-meningitis with involvement of the spinal nerve roots is the essential lesion. In another group of cases the vertebral column is especially involved, and in such cases the affection is probably allied to chronic rheumatoid arthritis. The following case appears to belong to this second group.

C. S., female, aged 17, a native of Pennsylvania. Father and mother in good health. One sister dead of pneumonia. Three sisters and two brothers alive and well. Paternal grandmother died of pulmonary tuberculosis. The patient was weak and undersized in childhood. Had scarlatina and parotitis at an early age. Puberty occurred in the fourteenth year. Menstruation was at first irregular, becoming regular in the fifteenth year, too frequent in the sixteenth, regular again in the seventeenth year, and during the last year the periods were sometimes delayed, but never painful.

Two years ago the patient while walking across the floor developed a sudden pain in the left knee. She "walked lame" for several weeks, and was placed in bed with "rheumatism" for a month or more. After four or five months she began walking with crutches. The leg finally became apparently well and she walked normally from September, 1898, until April, 1899. At that time pain developed in both groins and a physician was again called in. She was not obliged to go to bed, however, until June, 1899; she has remained in bed ever since.

On admission to the hospital the entire body was found much wasted. The patient laid on either side with both thighs flexed on the abdomen. There was marked fixation in adduction at both hip joints, and the right knee could not be completely extended. There was excessive hyperesthesia of the entire abdomen with rigidity of the abdominal muscles. The area of hyperesthesia began above at the eleventh rib and extended around the body obliquely downward to an inch above the umbilicus, and was apparently symmetrical and extended to both groins and as far down the back as the end of the sacrum. The buttock, thighs and legs were not hyperesthetic. There was very marked hyperesthesia along the spine from the dorsal region down, and this was especially marked in the lower dorsal, lumbar and sacral regions. Deep pressure over the spine produced great pain. The knee-jerks were both preserved but greatly diminished. The pupillary reflexes were normal. The shoulders and cervical spine were not involved. The sphincters were normal. Examination of the urine was negative.

## A CASE OF INTENSE INTERNAL HYDROCEPHALUS.

Dr. W. G. Spiller exhibited the brain from a woman who had been an inmate of the Pennsylvania Training School for Feeble Minded Children. The patient was sixty-two years of age, and had been under the care of Dr. Llewellyn, from whom the clinical notes were obtained. She had been a sickly babe, and was said to have been hydrocephalic from birth. Sight, hearing and speech were good. She had had epileptic attacks for years, and in these frothed at the mouth and had involuntary defecation but during the last six years of her life none of these attacks were observed. She occasionally had vertigo or vomiting. No motor paralysis was ever detected, excepting that she walked as though she were lame. She was a fairly intelligent person. The ventricles of the brain were greatly enlarged and the cortex and adjoining white substance were much atrophied, and measured in thickness scarcely more than a quarter of an inch. Sufficient cerebrospinal fluid was collected to nearly fill a quart basin, and yet some escaped. The absence of feeble mentality and paralysis in a case of such intense atrophy of the brain was noteworthy.

Dr. Charles K. Mills said that this specimen reminded him of the first case of hydrocephalus which he had examined post mortem, a case at the Elwyn Training School. The man lived to the age of about 50 years, and had pretty fair preservation of brain power. The brain presented much the condition seen in this specimen. It is interesting to consider how the brain adapts itself to the rest of the body and the rest of the body to the brain in these cases. He believed that the slow increase in the fluid and the slowly increasing compression of the tracts and the cortex of the brain, accounts for the preservation of the motor and other functions, as well as of some mentality, the brain accommodating itself to the slowly acquired new conditions.